



Health Services LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

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December 14, 2011

TO: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: *MH Katz* Mitchell H. Katz, M.D. *MHK*
Director

SUBJECT: **STATUS REPORT ON HEALTHY WAY LOS ANGELES
ENROLLMENT AND THE 1115 MEDICAID WAIVER**

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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.



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On June 14, 2011, your Board instructed the Chief Executive Officer and the Director of Health Services to report back in 90 days and monthly thereafter with data regarding enrollment trends in the Healthy Way Los Angeles (HWLA) Matched and Unmatched programs. On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of the Department of Health Services (DHS), and the Directors of Mental Health (DMH) and Public Health (DPH) to report back to the Board within 30 days and monthly thereafter on a proposed plan to implement the Medicaid Waiver (Waiver). This report is in response to both motions.

HEALTHY WAY LOS ANGELES – LOW INCOME HEALTH PROGRAM (LIHP)

Network Update: On June 14, 2011, your Board approved the new HWLA agreements with Community Partners (CPs) covering HWLA Matched and Unmatched Services. This new agreement replaced the previous Public -Private Partnership Program, HWLA and SB 474 contracts. On September 20, 2011, your Board delegated authority to DHS to execute amendments to existing HWLA-Matched agreements and to offer new HWLA-Matched agreements, to accommodate the transition of current Ryan White Care Act program clients to HWLA. We received signed contract amendments from all, but a few Ryan White providers and CPs and will synchronize our transition process with the State and DPH.

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HWLA Enrollment Status and Trends: HWLA is part of the California Health Care Coverage Initiative that seeks to expand health care coverage for eligible individuals in Los Angeles County. The initial HWLA program began in September 2007. The HWLA program with new programmatic and enrollment requirements commenced on July 1, 2011. As of November 30, 2011, over 100,000 individuals have been enrolled in the HWLA program.

One of DHS' immediate goals is to enroll eligible patients within DHS operated facilities, CP clinics, and DMH-operated clinics into the HWLA Matched Program. In order to accomplish this goal, the newly formed DHS Ambulatory Care Network (ACN) team spearheaded a campaign entitled Operation Full Enrollment. At the end of November, this intensive "in-reach" campaign, which included phone calls and patient outreach through the use of volunteers officially ended.

The campaign's achievements include almost 150,000 telephone or direct patient contacts made by DHS staff. During this campaign, El Monte, Mid-Valley and Humphrey Comprehensive Health Centers, and High Desert and MLK Multi-Ambulatory Care Centers exceeded 1,000 new HWLA enrollees. Hudson Comprehensive Health Center, Harbor-UCLA Medical Center and Olive View Medical Center exceeded 2,000 new enrollments, and LAC+USC Medical Center exceeded 4,000 new enrollments. Rancho Los Amigos National Rehabilitation Center exceeded 100% of its target enrollment population. Total new enrollment in DHS has exceeded 22,800 (See Attachment 1).

Since July 1, 2011, CPs have enrolled over 21,400 patients and DMH has enrolled over 1,400 patients. More than 45,000 new HWLA patients have been enrolled over the past five months. This is more than a 70 percent increase from the total number of enrolled HWLA patients prior to July 1, 2011. Although Operation Full Enrollment has ended, DHS, the CPs, and DMH continue to enroll all eligible HWLA patients.

Community Partner Update: Feedback from CPs and DHS staff continues to be incorporated. The weekly HWLA support call for stakeholders continues to average 50-60 participants with timely answers and report backs to the group. The website (www.ladhs.org/hwla) continues to be updated with content for providers and staff as well as for patients and the general public. DHS has recently made two modifications to the enrollment and billing process to make it easier for CPs to enroll and cover patients in a manner that is more convenient and timely.

DHS continues to seek feedback from stakeholders through a variety of community clinic and social service meetings. In the past few months, a number of operational issues have been identified and significant progress has been

achieved. As a result of the strain experienced by the CPs from a combination of the managed care Medi-Cal Seniors and Persons with Disability transition and HWLA programmatic requirements, we plan to bring to the Board recommended contract amendments to help ease the process.

Future Steps: Over the past three months, DHS, along with DMH and CP representatives have been working extensively with the Department of Public Social Services on a how to ease the enrollment process for both staff and patients. Representatives have been detailing the content and process flow for LEADER and Your Benefits Now . This is viewed as an important technical improvement from the current enrollment platform. A number of the challenges that have been identified in the existing enrollment process are being addressed in these detailed requirements meetings. The estimated implementation date for the new system is May 2012.

ENROLLMENT OF SENIORS AND PERSONS WITH DISABILITIES (SPDs)

In the first six months of SPD enrollment (June 1 to December 1, 2011), the net SPD L.A. Care enrollees assigned to DHS primary care providers was over 18,000 (>60% of our enrollment target of 30,000). The original intent in enrollment planning between DHS and L.A. Care was to enroll SPD patients that have previously received care from DHS, but the majority of the SPD patients enrolled in DHS are new. In order to meet the service needs for the SPD patients, DHS and L.A. Care staff are meeting regularly and working collaboratively to improve our care coordination and care transition processes. We are reviewing the financial impact of the SPD patients and will work with L.A. Care to determine whether or not we should adjust the enrollment target.

IMPROVING PRIMARY CARE LINKAGE AND SPECIALIST ACCESS

As we transform our system to meet health care reform requirements, improving primary care linkage and specialty care access is critical. For the last six months, DHS staff identified patients seen in DHS specialty care and urgent care clinics, as well as DHS emergency rooms, who did not have a primary care provider.

Patients identified in this process are those who no longer need specialty care or who could be more effectively co-managed by the primary care provider and specialist. In collaboration with our CPs, DHS identified and linked approximately 22,000 patients to CPs. We are working with the CPs to determine the final number of patients that actually scheduled and kept primary care appointments with the CPs for the first quarter. Given the strain experienced by the CPs, we will temporary delay the assignment of the remaining specialty service patients to CPs.

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This will enable both DHS and CPs time to review how we can improve this process to link patients back to primary care providers.

DHS, CPs, and L.A. Care are also working together to modify a telehealth technology (eConsult) that enables primary care providers and specialists to exchange consultations in a “store and forward” manner. This is a proven intervention that has worked well in San Francisco and Los Angeles, as well as other safety net and integrated delivery systems.

DELIVERY SYSTEM REFORM INCENTIVE POOL (DSRIP)

DHS will report to the State and CMS progress toward achieving the milestones for Demonstration Year (DY) 7 by March 31, 2012. Attached is a summary of relevant updates for each milestone.

NEXT STEPS

As directed by your Board, DHS will continue to provide monthly reports regarding HWLA enrollment trends and the status of implementing the 1115 Waiver. The target date for the next status report is January 13, 2012. If you have any questions, please contact me or Dr. Alexander Li, Ambulatory Care Chief Executive Officer, at 213-240-8344.

MHK:sr

Attachments

c: Chief Executive Office
 County Counsel
 Executive Office, Board of Supervisors
 Mental Health



OPERATION FULL ENROLLMENT
Data Report - DHS Enrolling Sites
Week Ending December 11, 2011

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Week 16	Week 17	Week 18	Week 19	Week 20	Week 21	Week 22	Week 23	Total Enrollment		
DHS Enrolling Sites	7/11-7/12-	7/12-7/13-	7/13-7/14-	7/14-7/15-	7/15-7/16-	7/16-7/17-	7/17-7/18-	7/18-7/21-	7/21-7/22-	7/22-7/23-	7/23-7/24-	7/24-7/25-	7/25-7/26-	7/26-7/27-	7/27-7/28-	7/28-7/29-	7/29-7/30-	7/30-7/31-	7/31-7/32-	7/32-7/33-	7/33-7/34-	7/34-7/35-	7/35-7/36-	7/36-7/37-	12/11 - 12/12	
BELLFLOWER HC	37	12	26	27	10	5	6	3	15	4	7	7	24	0	3	28	8	9	4	20	0	0	0	0	0	255
EDWARD R. ROYBAL CHC	10	15	82	41	76	16	13	24	14	28	33	29	46	41	34	40	10	71	38	31	9	39	29	29	29	769
EL MONTE CHC	61	123	46	124	63	127	124	110	17	3	156	124	133	90	67	97	37	55	93	129	27	114	63	114	63	1,983
H. CLAUDE HUDSON CHC	54	180	63	72	70	99	128	115	95	44	91	109	71	109	43	140	63	85	103	88	43	97	128	128	2,090	
H.H. HUMPHREY & DOLLARHIDE**	54	62	93	149	14	5	78	35	89	26	122	96	117	57	31	46	67	67	82	38	37	35	26	26	26	1,426
HARBOR+UCLA MED CTR	26	93	152	89	122	123	163	168	135	187	173	92	111	94	158	122	137	77	83	56	53	76	2,645	2,645	2,645	
HIGH DESERT AREA**	1	48	26	59	73	83	44	98	65	41	71	71	73	121	84	86	56	55	53	42	46	90	54	54	1,440	1,440
LA PUENTE HC	28	5	25	9	19	4	12	4	24	6	24	6	9	11	3	3	9	8	10	12	3	9	6	6	6	224
LAC+USC MED CTR	135	123	325	173	120	257	205	201	233	182	196	107	255	247	185	254	260	260	169	191	138	200	108	200	108	4,504
LONG BEACH CHC	35	53	34	35	32	6	7	46	24	4	9	57	26	9	3	43	53	49	18	31	18	53	28	28	28	673
MID-VALLEY CHC & GLENDALE†	1	39	39	65	48	39	45	38	48	52	69	46	57	57	38	77	68	79	59	41	22	49	41	41	1,117	
MLK MACC	16	23	8	122	47	107	172	94	174	98	146	121	71	64	106	91	43	40	95	14	71	107	60	60	1,890	
OLIVE VIEW+UCLA MED CTR	22	34	43	38	114	145	217	198	125	211	111	149	157	62	85	208	99	138	187	86	88	88	88	88	2,757	
RANCHO LOS AMIGOS NRC	11	19	11	26	9	5	11	23	17	25	15	28	33	22	12	25	26	34	31	44	19	31	15	15	15	492
SAN FERNANDO HC	9	24	31	18	9	38	14	0	1	51	10	33	17	17	22	14	26	27	20	8	18	9	8	8	424	
WILMINGTTON HC	0	0	0	0	9	10	7	11	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	41	
UNKNOWN DHS SITE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	18	14	91	150	
TOTAL DHS	500	853	984	984	1,063	826	1,084	1,165	1,196	1,129	838	1,347	1,118	1,203	1,113	767	1,187	1,056	1,076	949	910	712	986	821	22,880	

* Target is 75% of total patients eligible for HWLA.

** Hubert H. Humphrey CHC is doing the scanning for Dollardithide HC. Their inreach and enrollment numbers are combined.

*** High Desert area includes High Desert MACC, South AV, Little Rock, Lake Los Angeles, and AV HC. High Desert MACC is doing the scanning for all facilities in the region, therefore all numbers are combined.

† Mid-Valley CHC is doing the scanning for Glendale HC. Their inreach and enrollment numbers are combined.

Project	Milestone	DSRIP DY 7 Milestones	December 2011 update
Implement and Utilize Disease Management Registry Functionality		Disease management registry functionality is available in at least one clinic in each of at least 8 DHS facilities. At least 55% of patients with diabetes, heart failure or asthma seen in the clinics with registry access are entered into the registry.	DHS signed a contract with the new Disease Management Registry (DMR) vendor. [2j] on October 21, 2011. Implementation will begin in January 2012 and continue throughout the Winter and Spring of 2012. DHS will report compliance with the DY7 milestone based on usage of the previous DMR.
Enhance Urgent Medical Advice		Expand access to NAL by 10% over baseline.	Data on NAL usage rates is being collected and will be trended on a quarterly basis. Current usage is >10% over baseline based on six-month comparison period.
Enhance Coding and Documentation for Quality Data		Increase by 10% over baseline the number of NAL patient contacts who reported intent to go to the ED for non-emergent conditions but were redirected to non-ED resources.	All facilities have SO10 upgrades; message testing is still in progress.
Enhance Performance Improvement and Reporting Capacity		Implement HIPAA 5010 transaction sets to be able to communicate with institutions that are able to receive and send such transactions.	DHS employees require only minimal training on workflow changes related to implementation of HIPAA 5010. DHS is currently in the process of developing a plan to train staff on changes in workflow required for ICD-10 conversion.
Expand Medical Home		Participate in CHART or other statewide, public hospital or national clinical database for standardized data sharing.	As of December 2011, Harbor UCLA, LAC-JUSC, and Olive View Medical Center continue to report data to CHART (California Hospital Assessment and Reporting Taskforce) as well as to the University Health Consortium (UHC). Rancho reports Functional Independence Measures (FIM) to the Uniform Data System for Medical Rehabilitation; it is in the process of initiating participating with UHC as well.
Expand Chronic Care Management Model		Share quality dashboard or scorecard (including patient satisfaction measures) with organizational leadership on a regular basis; post on DHS public website.	Performance measures are continually reported to senior leadership. DHS public website continues to report quality and patient satisfaction data.
Category I			
Integrate Physical and Behavioral Health Care		Ensure at least 20 primary care providers deliver care using the medical home model.	128 medical home teams (providers and associated nursing/clerical support staff) have been designated and formed. Teams have begun working together, practicing according to the medical home model. By the end of December 2011, 45 teams have undergone simulation training on the medical home model of team-based care delivery.
		Assign at least 10,000 patients to provider-led medical home teams.	DHS has empaneled 240,000 patients into medical homes in DHS operated clinics.
		Determine baseline percentage of patients with diabetes, heart failure or asthma with at least one recorded self-management goal.	DHS will await implementation of [2j] before collecting and reporting baseline data.
		Implement a comprehensive risk-reduction program for patients with diabetes mellitus that includes glycemic, blood pressure and lipid control in primary care. Target patients include those with Diabetes related inpatient admissions and those with high risk score (HgA1c + IDL + BP).	A comprehensive risk-reduction program has been implemented among high risk patients with diabetes. DHS will continue to monitor the effects of this program.
		Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types.	Baseline established in June 2011. Individual clinics are increasing their use of "nontraditional" visits in order to more effectively and efficiently serve patients.
		Determine baseline: Blood pressure control among patients with completed stroke who are empaneled at any primary care medical home with registry access.	DHS will await implementation of [2j] before collecting and reporting baseline data.
Category II			
		Co-locate mental health services with primary care in 4 LAC DHS directly operated or contract facilities.	Five co-location sites are currently operating [El Monte, High Desert, Humphrey, Long Beach, Royal]. Staff recruiting efforts continue at MLK & Mid-Valley. Hudson will be added as a co-location site once adequate space has been identified.
		Track referrals from primary care providers to on-site mental health professionals to be used at the co-location sites.	Tracking mechanism is in place.
		Use joint consultations and treatment planning at co-location sites, and coordinate resources to improve patient education, support, and compliance with the medication regimen.	A draft joint consultation policy has been developed; it will be piloted and then further refined in Winter 2012.
		Integrate depression screening to 15% of enrolled patients with diabetes assigned to co-location sites.	Baseline data will be collected in January 2012. If needed, providers will be further educated regarding indications and methods for screening patients with depression.
		Ensure at least 70% of initial behavioral health visit appointment waiting times among patients enrolled in DHS medical homes who meet medical necessity criteria are less than 30 business days.	DHS is working on processes to efficiently collect and report data. Initial data will be available in Winter 2012. Co-located DMH staff are adjusting referral flows in response to high referral volumes at specific co-located clinics in order to achieve mandated access standards for managed care populations.

Project	DSRIP DY 7 Milestones	Milestone	Category III
			December 2011 update
Patient/Care Giver Experience	Undertake the necessary planning, redesign, translation, training, and contract negotiations in order to implement CG-CAHPS (Clinician and Consumer Assessment of Healthcare Providers and Systems) in DY8		DHS is preparing for contract negotiations with the CG-CAHPS survey vendor.
Care Coordination	Report the following: Numerator: All inpatient discharges from the DPH system of patients age 18 - 75 years with ICD-9-CM principal diagnosis code for short-term complications (ketacidosis, hyperosmolarity, coma) within the demonstration year reporting period Denominator: Number of patients age 18 - 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months		The Office of Planning has pulled preliminary data for DY7 metrics. It is working with IT to ensure DHS has the infrastructure needed to report metrics that begin in DY8.
Preventive Health	Report the following: Numerator: All inpatient discharges from the DPH system of patients age 18 - 75 years with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication within the demonstration year reporting period Denominator: Number of patients age 18 - 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months		
At Risk Populations	Report the following: Numerator: All patients age 18 - 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl) within the demonstration year reporting period Denominator: Number of patients age 18 - 75 years with diabetes mellitus who have visited the DPH system primary care clinic(s) two or more times in the past 12 months		
	Report the following: Numerator: All patients age 18 - 75 years with diabetes whose most recent hemoglobin A1c level is in control (<9% within the demonstration year reporting period) Denominator: Number of patients age 18 - 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months		

Project		DSHP DY 7 Milestones		Milestone	Category	IV	December 2011 update
Improve Severe Sepsis Detection and Management	Form DHS wide Sepsis Collaborative	Revise CME approved curriculum used to train ED nurses and physicians in the detection and treatment of severe sepsis and septic shock patients	Train 30% of ED nurses and physicians on severe sepsis and septic shock detection and treatment	Create Sepsis Resuscitation Order Set that includes the resuscitation bundle elements.	Allocate resources for expert support	Allocate resources for data collection methodology development	Allocate resources for data collection
							Report at least 6 months of data collection on Sepsis Resuscitation Bundle to Safety Net Institute (SNI) for purposes of establishing the baseline and setting benchmarks.
							Report the Sepsis Resuscitation Bundle results to the State.
							Develop a mandatory curriculum/ used to train and orient physicians in the insertion of central lines
							Provide ongoing education to ICU staff on care of central lines
							Allocate resources to provide expert support
							Allocate resources to develop data collection methodology
							Allocate resources to collect data on implementation of central line bundle
							Report at least 6 months of data collection on CLIP to SNI for purposes of establishing the baseline and setting benchmarks.
							Report at least 6 months of data collection on CLABSI to SNI for purposes of establishing the baseline and setting benchmarks.
							Report CLIP results to the State.
							Data from first six months of DY7 to be reported to the State in March 2012
Reduce Complications of Surgical Procedures	Assess understanding of and compliance with SCIP Core measures for identified procedures using UHC Core Measure Data set	Address provider knowledge deficits using a variety of strategies e.g., team training	Develop dashboard to compare compliance with SCIP Core measures using UHC Core Measure Data for CDPH targeted procedures	Report at least 6 months of data collection on SSI to SNI for purposes of establishing the baseline and setting benchmarks.			Data from first six months of DY7 to be reported to the State in March 2012
							Report results to the State.

Project		DSRIP DY 7 Milestones		Milestone	December 2011 update
Venous Thromboembolism (VTE) Prevention and Treatment		Form DHS VTE prevention collaborative		Completed	
		Set General goals and a timeline for construction of and implementation of VTE protocol		Completed	
		Allocate resources for expert support		Completed	
		Allocate resources to develop VTE data collection methodology		Completed	
		Allocate resources to collect data on VTE measures		Completed	
		Report at least 6 months of data collection on the VTE management process measures to SNI for purposes of establishing the baseline and setting benchmarks.		Baseline data collected and validated; ready for reporting to SNI	
		Report the 5 VTE process measures data to the State.		Data collection in process; to be reported to the State at end of DY7 reporting period	